

<b>Case Number:</b>	CM15-0147918		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	10/08/2014
<b>Decision Date:</b>	09/08/2015	<b>UR Denial Date:</b>	07/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 51 year old female, who sustained an industrial injury on 10-8-14. The injured worker has complaints of back pain and left shoulder pain. The documentation noted that there is tenderness of the left sternoclavicular and acromioclavicular joints. The diagnoses have included sprain and strain lumbar; strain and strain left shoulder. Treatment to date has included tramadol; acetaminophen; back support; cold pack and heating pad. The request was for chiropractic therapy, hip, lumbar, sacral vertebrae, 3 times weekly for 2 weeks, 6 sessions. A utilization review determination recommends certification for 6 sessions of physical therapy and non-certification of chiropractic care. Notes indicate that the patient underwent regular chiropractic care from April through June 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Chiropractic Therapy, Hip, Lumbar/Sacral Vertebrae, 3 times wkly for 2 wks, 6 sessions:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines: Chiropractic Guidelines-Therapeutic care.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, 2009) Page(s): 58-60 of 127.

**Decision rationale:** Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.